TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-17-3168-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement was inaccurate. Based on DRG 520, expected reimbursement $9,684.35 multiplied at 143% should be $13,848.62. Payment received was only $13,051.62 thus, according to these calculations; there is a pending payment in the amount of $797.00."

Amount in Dispute: $797.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs and the reduction rationales stated herein. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2017 to March 01, 2017	Inpatient Hospital Services	$797.00	$718.25

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. 28 Texas Administrative Code §133.240 sets out the processing of medical payments and denials.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation Jurisdictional fee schedule adjustment
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 4896 – Payment made per Medicare's IPPS methodology, with the applicable state markup
   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule for determining reimbursement of the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied payment for the disputed services with claim adjustment reason code "45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement."

   Review of records held by the division finds no information to support that the insurance carrier has notified the division that the injured employee has been enrolled in a Certified Workers' Compensation Health Care Network (HCN) established in accordance with Insurance Code Chapter 1305. The response does not include any documentation to support that the injured employee is enrolled in a certified Workers' Compensation HCN.

   28 Texas Administrative Code §133.240(f)(15) requires that the insurance carrier shall include the workers' compensation health care network name (if applicable) on the paper form of an explanation of benefits. While the explanation of benefits mentions the name "TRPN Pend and Transmit" and "Procura/TRPN" – TRPN Pend, Transmit and Procura. TRPN is not itself a certified Texas Workers' Compensation Health Care Network established in accordance with Insurance Code Chapter 1305. TRPN Pend, Transmit and Procura TRPN is rather a trademark under which a variety of different networks (each with separate names) are marketed. "TRPN Pend, Transmit and Procura TRPN" is not the name of specific Texas Certified Workers' Compensation Health Care Network in which a Texas injured worker would be enrolled. Without listing the name of the specific Texas Workers' Compensation Health Care Network in which the injured employee is enrolled (if applicable), the insurance carrier has failed to meet the requirements of Rule §133.240(f)(15). Moreover, in the absence of any evidence to support that the insurance carrier presented clear information to the health care provider that the injured employee was enrolled in a certified workers' compensation health care network (HCN) prior to the filing of a medical fee dispute whether as a plain language notice on an explanation of benefits issued before the filing of a medical fee dispute, or otherwise the respondent has failed to meet the requirements for raising such defense.

2. This dispute regards the facility medical services of an inpatient acute care hospital with reimbursement subject to the provisions of Code 28 Texas Administrative Code §134.404(f), which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Per §134.404(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

Review of the submitted documentation finds that the DRG code assigned to the services in dispute is February 28, 2017 to March 01, 2017. The services were provided at Doctors Hospital at Renaissance. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount taken from the *Medicare Inpatient PPS Pricer* is $9,650.14. A "VBP" claim payment in the amount of $20.86 is then **subtracted** from $9,650.14, resulting in a facility specific amount of $9,629.28.

"VBP" stands for Value-Based Purchasing (VBP) payment. Medicare's VBP program was implemented to monitor and improve quality of care provided at inpatient hospitals participating in the Medicare system. The Medicare VBP conflicts with existing Texas Labor Code (TLC) sections 413.0511 and 413.0512 which provide for the review and monitoring of the quality of health care provided in the Texas workers' compensation system.

Pursuant to 28 TAC §134.404 (d)(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program. For that reason, the VBP amount does not apply and was therefore subtracted from the total indicated on the *Medicare Inpatient PPS Pricer.*

3. Per §134.404(f)(1)(A), the sum of the Medicare facility specific amount, including any outlier payment, is multiplied by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 520. The services were provided at Doctors Hospital Renaissance. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $9,629.28. This amount multiplied by 143% results in a MAR of $13,769.87.

4. The total allowable reimbursement for the services in dispute is $13,769.87. This amount less the amount previously paid by the insurance carrier of $13,051.62 leaves an amount due to the requestor of $718.25. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $718.25.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $718.25, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		7/27/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.